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By-Blum, Richard H.

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Drug use and abuse have two major motivations: the medical or curative, and the religious or supplementary. The author discusses the expanding use of drugs for both purposes, suggesting a possible connection between increased medical use and confidence, and increased religious or pleasure use. He outlines many problems of definition and public relations encountered in studying student drug use. Student's attitudes differ widely, as do administrators', parents', and those of other influential persons. The solution lies in education and dialogue, communication both ways between those who would solve the drug use problem and those who do not see it as a problem. Information and facts on the significance and effects of exotic drug use should be available through student personnel services. Student personnel workers can aim at the development, by students, group norms and inner standards which sensibly guide their conduct. (BP)

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National Association of Student Personnel Administrators
Drug Education Project (1966-67)
Background Papers

Drugs and Personal Values [1]

Richard H. Blum, Ph.D.

Director, Psychopharmacology Project,
Institute for the Study of Human Problems
Stanford University [2]

I am sure that it is out of your own formulations and observations -- and not those of experts -- that each of you will come to a position which will enable you to deal with the student drug use problem on your own campuses. The best the experts can do is to give background information to allow you to make enlightened decisions.

I am to talk about values and drug use. For myself, I cannot divorce the notion of values from the business of motives and of the social and historical context. Let me start by making an observation. It is simply that drug use today is in many ways not different from drug use not only yesterday but two or three thousand years ago. The motives associated with the use of drugs occur again and again. In this regard I suggest that in traditional societies the introduction of drug use has been associated with two radically different kinds of goals, or if you will, values; that is, for religious or medical purposes.

The religious orientation has essentially been an expanding one. That is, it proposes that there is something more in this world than the ordinary self and that the person can have access to that greater power. The person with this orientation uses drugs because he desires to experience that power, to get close to it, to know what it is. This religious drug use is a supplement, if you will, to where man already stands. It may be an ecstatic supplement in the sense that one has experiences ordinarily denied. One has an orgy or a delight or a spasm of joy, whatever you want to call it, or it may be a profound mystical experience or simply a sensitive and beautiful feeling.

The other theme, the medical theme, has been that of healing or pain killing. It does not seek to supplement ordinary life but rather to bring the person back to where he once was or to put him in a position where he can function adequately. Traditionally the use of psychoactive drugs has been for the relief of pain and anxiety. These, the tranquilizers as well as the narcotics, comprise the largest category of drugs used medically.

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2. Also, Consultant, President's Commission on Law Enforcement and Administration of Justice.

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Another study we have been involved in has been a cross cultural study. Here we are interested in the characteristics of non-literate societies in which drug abuse occurs as opposed to the characteristics of societies in which drug use but no apparent abuse occurs.

We were also involved in some pilot studies of normal population drug use. To me a critical question is what do ordinary people do? What is the norm? What happens? What is the convention in our society with reference to the use of drugs? When I say "drugs", of course I mean now explicitly psychoactive drugs, those drugs which alter mind and mood and cycles of sleep and wakefulness. Having done this other work, we have been involved in the last year in the studies of student drug use. These are under way but we now have only preliminary data.

So much for the kinds of things we have done; you can note what we have been interested in and can quite clearly infer the large areas of our ignorance and inattentiveness.

Now let me share with you, if I may, some of the troubles we run into when we are trying to assess student drug use, which is the common grounds that brings us together here.

First of all, what drugs are we interested in? We use the word "drug" and we use it rather loosely. "Narcotics" is an example of a word that is used atrociously. Do we care about aspirin, and do we care about tobacco, and do we care about medically prescribed barbiturates? Or do we care only about the exotic drugs, LSD, marihuana and heroin, which certainly represent a very small part of the spectrum of drugs which are available and are employed?

I know that Joel Fort, who follows me, will spend a great deal of time with you talking about each of these possible classes of drugs, and I suspect he will warn you that the classifications that we use are rather inadequate.

The drugs we have been interested in, in our college studies, have covered quite a broad range. We have been interested in the stimulants, the mild ones and the strong ones, in the analgesics and the opiates, in tranquilizers both mild and strong, in the psychoenergizers or anti-depressants, in the hallucinogens (which, by the way, rarely cause hallucinations), and we have been interested in the intoxicants. In addition, we can't help but be interested in tobacco since that is a very common addicting drug if we dare to use the word "addiction", itself so fraught with misunderstanding.

As I list these drugs, you see the trouble. It is a mixed bag. Sometimes we are talking about a group of chemicals which share a similar structure. Some other times we are talking about a popular name. Sometimes we are talking about a group of drugs which are defined by their presumed effect, and, as Dr. Nowlis so well put it, those presumed effects occur only under certain circumstances, only when the probabilities are running our way, for example when we have set up our experiment, social or clinical, in a way that we get the kind of drug behavior we expect.

A second problem that I face, and I think you face it with me, is getting adequate data once we know what drugs we care about. The problem here is simply talking to people. They often don't know what they have been taking.

Certainly, over their lifetime they would be unlikely to know their exact history of drug use. Even if people do know at least some of the substances they have been taking, they may not be willing to tell you about it. Here, of course, you run into a problem which plagues psychiatrists and criminologists. Just because I am interested in asking doesn't mean they are interested in telling, and there are some very good reasons why they shouldn't be. So we can get under-reporting when we ask some students about what they really did yesterday or what it is they plan to do tomorrow.

Another problem which I face, which you may run into on your own home grounds, is access to institutions. For instance, we are trying to study high school drug use, yet it will be a cold day in hell when they let us in any high school to do our study -- and again for a lot of good reasons that you know, such as the fears of the board of trustees, the newspapers, and the community. It can be a curious combination of the left-wing and the right-wing ideologists ganging up, saying, "Don't you dare ask my kid anything which doesn't have to do with the date that George Washington chopped down the cherry tree."

In any event, we are not allowed to intrude on the private affairs of the students. Indeed, we have recently had the same thing happen in some of the colleges which we have approached. They have said, "Well, we certainly understand your interest in drugs, and we share that interest, but what if you found out?"

Given the premise we might find out and that some enterprising reporter might make some links -- links which we would try to prevent being made -- nevertheless, the schools have refused us permission.

I am not saying the reluctant college is wrong. I am saying we are living on many campuses in an atmosphere of politics and emotion. Feelings are so intense that people can be afraid to assess the facts. When that is the case we are in trouble, because if we cannot find out what is going on, then how can we possibly know what to do, and how can we possibly say, "Here is our problem or our non-problem." I suspect some of you on your own campuses will run into some trouble either in assessing drug use or perhaps in developing programs directed at drug problems.

Another problem we have, which is a technical one but which really interferes with much discussion, perhaps even our discussions here, has to do with the definition of "use". "He is a pothead. He is a user," meaning that a student, now age twenty, when nineteen did one evening, in company with others, illegally acquire and illegally possess marihuana and further did take three puffs of a "joint". That can be one definition of a drug user. Or again, "Yes, he is a real LSD user," which might mean that a student took LSD once two years ago and wouldn't touch it now for love or money. So it is that when we talk about use we have to be careful to specify what kind of use. Are we looking at a life-time pattern for one drug? Are we looking at a daily pattern or a weekly pattern for a variety of psychoactive drugs? Are we looking at what he expects to do tomorrow as well as what he did yesterday? Are we looking at the rather important pharmacological facts of when did he take it, how much did he take, by what route of administration did he take it, and how often with what result?

As we approach our college populations we are well advised to discriminate between those who have used an elicit or exotic drug in an exploratory fashion, and those people who are, if you will, "committed" users, the people whose lives are built around drug use. I think you will find the size of your two samples differs rather dramatically.

Later on when we talk about communicating to drug users, teaching students about drugs, we will have to keep in mind what kinds of drugs, what kinds of students, and what kind of use.

Now, assuming that we have found out, which we have not yet, but assuming the "as if" of what is going on on the campuses with regard to drug use, let us consider some of the premises upon which we are beginning to operate, one of which is that students, at least in some colleges, are using more drugs without medical supervision.

Our concern then is over the social use of drugs, in particular the exotic and illicit drugs, not alcohol or tobacco even though those are potentially dangerous indeed. From an epidemiological standpoint one should also ask, "Are students using more drugs in approved ways as well?" That is, are alcohol and tobacco more used than five years ago, or are medically prescribed drugs being used more often as well? One suspects that with increasing medical care and with the increasing reliance of physicians on pharmacotherapies that it may also be there is a simultaneous growth in the medical as well as in the non-medical employment of these substances.

Another premise which brings us together with a shared concern is that there are ill effects which are associated with drug use.

Another thing that many of us assume is that what is "bad" about drug use is not just a matter of physiological or psychological ill effects but, rather, that it is part of an unsettling social package. One sees illicit use occurring in association with other social trends in student behavior, trends not approved by some of us, trends which can jostle or shake us up a bit. It may be that the entire pattern of conduct "bugs" us and that student drug use is something on which we can focus our worries. Implicit in that worry may be our awareness that there are changes in values and standards which go beyond beards and sandles, changes which reflect fundamental challenges to social codes which adults hold and which the elders think students also ought to hold. Here we are asking ourselves, what is acceptable conduct? What <u>is</u> an acceptable goal in life? What are acceptable means to those goals?

Unquestionably, student use of exotic drugs in any regular way does itself challenge conduct standards that many thought were pretty stable, standards one thought were going to stay with us for awhile.

Let us say that these premises which may account for college administration worry about drug use are correct. This is not to say they are, but let us act as though they were, at least until the data are in. Now let us consider the increasing frequency of drug use among students.

First I would point out that there are very clear differences among campuses in the extent to which exotic drugs are available, and there are dramatic differences in student attitudes towards the use of these substances.

In one college in which we are doing a study we asked the people working with us there to find a sample of "hippies", the people who are using the stuff. They have been looking now for two or three months, and they do not have hippie number one. He does not exist. They found a lot of hippies who used to be, that is they used to be on campus, but they have left; and in this particular school, which is a very traditionally oriented and religious university, it seems to be the case that when the student begins to use marihuana or LSD it is part of a general life change. Perhaps he is rejecting a lot of values, and whether drug use is symbolic expressive or causal of later shifts nobody knows. Nevertheless the student seems not to stay there after he has started using pot or LSD.

In another school which is not more than fifteen miles away by crow or dilapidated bus we sat down in a coffee shop and we asked, "Do you know anybody who is using?" The guy looks at us and says, "How much do you want " We say, "No, man, we don't want any," and he says, "What do you want to do then?" We talk awhile and he may say, "Yes, sure, I have some pot," and he pulls it out of his brief case, saying, "I try not to smoke it in class." Well, so much for campus differences.

In assuming that drug use is increasing among students to an unknown point, it is less and less easy to make generalizations about the characteristics of users; more different kinds of people are involved. In the old days, two years ago perhaps, one could propose that people smoke pot because they are rebellious characters, thumbing their noses at the system and trying dangerous behavior. That was all very fine to say as long as pot smoking was highly disapproved and had to be rebellious, but now when you have campuses where "X" number of kids are using pot and it is the thing to do, to at least say one has had it, and the student would be ashamed of himself if he did not, it would be foolish for us to assume that one particular kind of personality or attitude or social background is associated with what is now popular experimental behavior. That is to say on some campuses anyone can be expected at least to try marihuana regardless of whether he continues with that behavior later on.

We already have diversity in student conduct and we shall get increasing diversity. As we all know, the kinds of people who are going to be innovators and the kinds of people who are going to be followers are likely to be different from one another in many ways. So it is we must not lump the motives and personalities of student drug users in one common category. Diversity there will also be the rule.

A problem rarely mentioned and which, I think we must call attention to when we accept our premise of expanding drug use, has to do with the role of physicians in contributing to the expanded use which we see. From our pilot survey we have some evidence that the people who became exotic drug users, and this tends to be a well-educated young sample in a normal population, had larger exposure to medical care. Their parents had been more interested in giving them drugs, and they had been more often taken down to the doctor when they were kids, and they learned to take drugs. They had become drug optimists, if you will, and I suspect many of us are drug optimists. We give a great vote of confidence to the pharmaceutical industry and to modern medicine. Many of us are taking their products, tranquilizers, barbiturates or what have you, and we expect to use them in our lives. We have learned to do that. So it is that we should not overlook the role

of the physician as an instructor in drug use. There can be a carry-over, beyond what the physician or parent anticipates, but which is a natural consequence of the child having learned that drugs are to use. That in itself is part of our technological society. We believe we can control our insides with these little capsules. It is a very simple belief -- and a correct one in some ways -- yet its ramifications are immense. How could we expect our children not to take drugs if this is what we have taught them?

Let me illustrate. In our early LSD studies it was clear the drugs which were being used came from doctors, and they were then distributed socially to their friends and sometimes to their experimental subjects. Similarly on college campuses we find the doctor in the health service gives amphetamines and he gives barbiturates, and the kids will spread the extra ones around. We also have found kids with parents who are physicians, who are really tremendous suppliers on campus for almost everybody's needs. It is fun to play doctor, and it is nice to be good to your friend, and so prescription drugs get spread around. I remember Dr. Bruyn from U.S.'s health service telling about one college newspaper which had a big advertisement from the Student Health Service, which said, "Examination times are coming up, and if you want your amphetamines for staying awake, come in and get them."

With that kind of service provided I don't think any of us should be terribly surprised if our students get used to using drugs. But let us not blame the physician for what is going on. In our LSD study and in our historical diffusion studies, we find -- and it is not a surprise -- that people learn from their elders and from respected "opinion leaders." Watching the LSD diffusion one saw that it went from the experimenters and physicians down to graduate students, from them down to college students, and nowadays from them down to high school students. So it is that I think most children have probably learned about drugs from their parents who are carriers of the larger culture. I expect to find a relationship between student drug use and the frequency with which parents accept drugs and use them. Surprising as it may seem, it is not impossible these days to find parents using LSD and marihuana who pass it along to their kids, and sometimes, of course, it is vice versa.

Clearly, it is not just a student phenomenon we are looking at. If you will, let me share a little gossip with you. I heard about a high school where they busted about fifteen kids for marihuana use. The school administrators said, "Oh horrors, disaster has befallen our fair community. The kids are smoking pot. How will their parents react?' A terrible thing? Well, one of the parents, I was told, who was a church deacon and a very respectable fellow, was a supplier. Of course, I do not know how he reacted but I imagine he was very glad they did not find the supplier. In any event, we cannot be too quick about estimating the parental role in student drug use. This is not to say that I think most parents are smoking pot. Far from it, but some will be.

Let us examine the premise of risk with which we concern ourselves. I guess we will not embark on any program to control drug abuse unless implicit in the definition of abuse would be the notion that it is something bad, something dangerous, that it is worth our trouble stopping. Now what are the kinds of abuses with which we concern ourselves?

Things I worry about and I gather that you worry about are dependency, on the one hand, or addiction as it is sometimes called, crime, immorality, traffic accidents, psychosis, suicide, illness, some kind of physiological change, tissue or metabolic change either acute or chronic, personality changes of an undesirable sort, a shift in social conduct or values of what at least the larger society would say would be undesirable, or finally, I think the embarrassment, pain and tragedy of arrest for the individual or the embarrassment for his family or his institution.

We cannot be too fast in leaping to the statement that the kind of illicit drug use we are concerned with can be shown to lead to such things. Indeed, I have been struck by the lack of data about the relationship between risk and drug use.

Dr. Nowlis talked earlier about there being no specific drug effect within the range of normal dosage which allows a guy to still move around and talk. You can get a very specific drug effect. You give them twenty grains of a barbiturate and you can be sure of what is going to happen, but with the dosage range of a grain or a grain and a half the person is going to have a lot of behavior choice still possible. So when we consider risk we have to be concerned with a lot of other things going on in the person, in his background, in his situation which would account for the production or non-production of the dangerous behavior that we worry about.

Curiously enough, the drug for which we have the best evidence of risk, of danger, is alcohol. That is one drug about which I can confidently be quoted, saying, "Yes, that is a dangerous drug, we can show relationships to traffic accidents, to homicide, to suicide, and to disease." But, again, it is not just taking a drink, rather it is drinking in conjunction with other things -- background, personality, setting, and what have you.

There is a lot of nonsense floating around about the other drugs. For example it is quite clear that heroin use is illegal and associated with all kinds of delinquency but it is not at all clear that heroin use leads to crime, since it is the delinquents who use heroin in the first place. That they stay delinquent cannot be blamed either on heroin or on the law making heroin illegal.

These kinds of cautions must be kept foremost in our minds before we go leaping into the fray with warnings to kids about what is going to happen if they use such and such. Usually we do not really know. The whole problem of assessing risk has to be related to different kinds of people using a drug, dosage, kinds of circumstances, and so forth. Then, if we knew all of that, we could say, "Okay, Jack, if you take this drug in this way, here are the probabilities of it going sour." Given the absence of facts and yet given also our common sense that these powerful agents can do damage, one of the most important things to be aware of, it seems to me, is the sense of alarm which outweighs the evidence at hand. The public assigns very peculiar priorities to their worries about drugs and the most peculiar priority is to put heroin at the top of the list. There are very few college students who will ever take it, and there are fewer who would become dependent if they did.

Considering public alarm over student drug use, we cannot help but face the special risk which is generated by public anxiety itself, that is the risk of our being forced to be premature in our actions. We are all in a spot. The danger is that we will act impulsively when the parents call and say, "What are you doing? What kind of a university is that? I heard there is marihuana on the campus. Stamp it out!" The alarm is a demand upon us, yet we should be very cautious not to let emotion drive us into corners. Of course that is easier for me to say, for I am not an administrator. I am not on the end of the telephone that jangles all day with the voices saying, "Do something!" Let us be aware of our own precipitous response as a serious risk.

We talk about risks, but let us not forget that most of the psychoactive drugs employed these days are used because of benefits. We use barbiturates to go to sleep, we use tranquilizers to reduce agitation in hospital wards. We use aspirin to get rid of headaches. Or we use alcohol for pleasure. Let us not overlook the fact that there are benefits associated with use. If there were not there would probably be very few users and neither a pharmaceutical nor a liquor industry. And so it is that people enjoy marihuana and they enjoy LSD.

What we must do is to balance the benefits against the dangers, but in alarm let us not speak as though we were unaware of the reasons for the being of these substances. Of course, we should also not forget that some of the benefits are a placebo effect.

In summary, we believe that exotic drug use is increasing, and we know that risks as well as felt benefits are there. We care enough about our students to want to reduce any dangers they face, yet we hesitate to restrict their freedoms and indeed, we may be unable to restrain their conduct by any administrative action open to us. The question of the efficacy of disciplinary, punitive or controlling actions as a means of influencing drug use goes beyond the consideration of student conduct, extending to the current state and federal laws as well. Although I think one can show an influence of the criminal law on the supply and distribution of drugs and quite possibly on decisions initially to use or not to use a drug, I am dubious if the punishment-control method makes much of a dent upon the convinced or committed user group. If that is the case, it would mean that we do not lose much by our reluctance or inability to apply sanctions against drug use.

I think the course best open to us in dealing with student drug use is that to which we are -- in conjunction with our students -- all dedicated. That is education. We are all educators and we must have great hopes for knowledge as a means of guiding lives or we would not be in the business. Why not then remain consistent to our calling and to our beliefs -- or even our mythology if it be that -- and emphasize fact-finding and information-giving as means to acquaint students with the significance and effects of exotic drug use? We can also be aiming, as we do in much of what is education for civilization, at the development by students themselves of group norms and inner standards which sensibly guide their conduct.

I further suggest that educational efforts not be limited to students alone, but directed at the drug gatekeepers. Here I mean physicians, parents, pharmacologists in our laboratories, our campus professors and the graduate students, for I suspect we shall find that with each new socially used drug that these people will be the channels for learning attitudes, use, and sources of supply. If we want to have an impact we must be talking to those who are models, those who are the opinion leaders for them -- and that is as it must be -- for education is a business of exchange, a dialogue, not a one-way street.